UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Remicade (infliximab) **for Plaque Psoriasis**

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#_____Ext. and options:_____Fax#_____

Physician's NPI:_____

Diagnosis_____Current wt_____mg/kg_____

Administered every_____weeks starting (date)_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO: 801-536-0477

CRITERIA:

- Age requirement: 18 years old and older
- Diagnosis of chronic severe Plaque Psoriasis
- History of incomplete response or intolerance to one appropriate systemic agent or photo therapy.
- Negative TB skin test or history of treatment for latent TB infection
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Dermatology consultation within the last 60 days.
- Remicade may not be given with other biologic agents such as Interferon, experimental medications or combinations.
- Remicade may not be given with Enbrel or Kineret.

INFORMATION:

To be given in clinic setting only. Patients on HMO's (except IHC) will have to make arrangements with their HMO for coverage.

Provider will bill with J code J1745 and PA number

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.